FOR OFFICE USE ONLY
Web Application
Receipt #
ID #
Issue Date
License #

Rhode Island
Board of Medical Licensure and Discipline

Room 205
Three Capitol Hill
Providence, RI 02908-5097

Instructions and Application For

License to Practice

☐ Allopathic Medicine

☐ Osteopathic Medicine

Applicant - Print Name (First/MI/Last)

☐ I am also applying for a RI Uniform Controlled Substances Registration (CSR) and have attached the CSR application to the last page of this application.

Phone: (401) 222-3855 **TTY/TDD: (800) 745-5555** **Fax: (401) 222-2158**

GENERAL INFORMATION

Enclosures

The following materials and information should be enclosed within this application packet:

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Licensure Requirements

U.S./Canadian Graduates

- Graduated from a medical school accredited by the Liaison Committee for Medical Education (LCME).
- Satisfactorily completed two (2) years of internship or residency by the Accreditation Council for Graduate Medical Education, Accreditation Committee of the Federation of the Medical Licensing Authority of Canada or the Royal College of Physicians and Surgeons of Canada.
- Satisfactorily passed a licensure examination approved by the Board.
- Met any other requirement(s) set forth by regulation or established by the Board.

Foreign Graduates

- Successfully completed a course of study from a medical school located outside the United States which is recognized by the World Health Organization.
- Obtained ECFMG certification.
- Have attained a score satisfactory to a medical school approved by the Liaison Committee on Medical Education on a qualifying examination acceptable to the State Board for Medicine.
- Have satisfactorily completed three (3) years of internship or residency in a training program accredited by the Accreditation Council for Graduate Medical Education.
- Have satisfactorily passed a licensure examination approved by the Board.
- Met any other requirement(s) set forth by regulation or established by the Board.

Rules and Regulations

The rules and regulations governing the Practice of Medicine can be obtained at the following web site:

http://www.rules.state.ri.us/rules/released/pdf/BMLD/BMLD_2961.pdf

Rhode Island General Laws pertaining to the Practice of Medicine can be obtained at the following web sites:

Medical Licensure	**http://www.rilin.state.ri.us/statutes/title5/5-37/index.htm**
Controlled Substances Act	**http://www.rilin.state.ri.us/statutes/title21/21-28/index.htm**

APPLICATION PROCESS OVERVIEW

The licensure process in the State of Rhode Island is conducted jointly by the Rhode Island Board of Medical Licensure and Discipline (Board) and the Federation of State Medical Boards' Federation Credentials Verification Service (FCVS). All licensure applicants must complete and submit a Board application **and** a separate FCVS application.

FCVS Application Process

To have your "core" credentials verified, you must submit an FCVS application directly to the Federation's national office (Texas). This application must be obtained by contacting the Federation toll free at **1-888-ASK-FCVS** (1-888-275-3287), or it can be downloaded at the Federation's web site at:

http://www.fsmb.org

This verification process is conducted separately and independently by the FCVS in accordance with established policies and procedures set forth by the Board. Because the verification process is the most time-consuming task, it is recommended that you submit this application as soon as possible. You will deal directly with FCVS for all aspects of this verification. **Do not contact the Board about your FCVS application.**

The FCVS will verify your applicable credentials from the original, primary source in the following categories (some may not apply):

- Medical Education (including Fifth Pathway)
- Postgraduate Training
- Examination History
- Board Action History
- ECFMG Certification
- Identity

When all information is received and reviewed for accuracy, FCVS will forward directly to the Board, a non-interpretive "Physician Information Profile" containing certified photocopies of your credentials. For more information about the FCVS process, or if you need assistance completing the FCVS application, call the Federation toll free at **1-888-ASK-FCVS** (1-888-275-3287).

Board Application Process

In addition to the FCVS application and verification process, you must submit additional information directly to the Board. The Board will use this information, along with the FCVS Profile, to assess your qualifications for licensure. Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have malpractice or disciplinary history, it can take an additional 2 or 3 months for all pertinent documentation to be received.

The Board meets during the first week of each month. Only applications which are complete, including all outside verifications, will be forwarded to the Board for review and issuance of a license. So that we can move the process along more quickly, if you are an endorsement candidate, and hold an active, unencumbered license in another state, your applications materials will be presented to the Board and a license may be issued **prior** to our receiving the FCVS application. If we thereafter identify any problems with your FCVS application, your license will be voided. Licenses will be issued within 7-10 working days following the Board meeting and are mailed to the address furnished in your application. You are responsible for notifying the Board office, in writing, if your address changes in the interim.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this application process, or would like to check on the status of your Board application, please contact Lauren Dixon at (401) 222-7887, or by email at LaurenD@doh.state.ri.us.

INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

Read the following instructions and those throughout the application packet carefully before completing the Board application. Failure to submit all required information and appropriate documentation may result in processing delays. All of the information provided is subject to change.

General Instructions

1. Make a copy of the application and forms before you begin, in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be sure to print your name in the box provided on the cover page.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to the Board.
5. It is your responsibility to check on the status of your application.

Completing your Board Application

1. Complete the **Board Application** pages (6-12). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the Board application, such pages MUST clearly indicate the section for which such information is being reported.
2. Make a check or money order (in U.S. Funds only) for the application fee of $437.50 (or $537.50 if you are applying for your Controlled Substances Registration (CSR)), payable to "Rhode Island General Treasurer" and staple it to the upper left-hand corner of the first page of the application. These application fees are NON-REFUNDABLE. If you are applying for your CSR, you MUST submit the Board application at the SAME TIME as the CSR application.

   NOTE: These are Board Application Fees. The FCVS verification fee is an additional and separate fee paid directly to the FCVS.

Complete all application materials as instructed and arrange them in order as they appear in the application checklist (see page 16). Do not submit applications without all applicable information, documentation and fee. Mail these components of the application to:

Rhode Island Department of Health
Board of Medical Licensure & Discipline
Room 205, Three Capitol Hill
Providence, RI 02908-5097

Physician-Initiated Requests

In addition to the materials you mail to the Board, you must also mail information to other sources for verification. Follow these additional steps as described below:

1. Obtain licensure verification from all states where you hold, or have ever held, a license to practice medicine. To obtain this verification, you must mail the **Reciprocity Release Form** (page 17) to each licensing authority in which you are/were licensed. If you are licensed in Canada, send a copy to each province in which you are/were licensed. Type your information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information.
2. Be certain to sign and complete the identifying information on each form. **The Board must receive the verification(s) directly from the licensing authority**. Make copies of the form as needed. You may obtain

the mailing address of all 69 U.S. medical and osteopathic licensing authorities at the Federation of State Medical Boards' web site at http://www.fsmb.org or by calling the Board in question. Please do not contact the Rhode Island Medical Board for mailing addresses of licensing authorities.

3. Submit a "self-query" of the National Practitioner Data Bank (NPDB). The application is a **Practitioner Request for Information Disclosure**, which can be obtained by calling the NPDB, or downloading it from the NPDB web site.

   Phone Number for NPDB Information: **1-800-767-6732**
   NPDB web site: **http://www.npdb-hipdb.com**

   You must mail this completed form directly to NPDB. **When you receive a response, send the Board the ORIGINAL, UNOPENED** response. The Board must have this response in order to complete your application so you are encouraged to make this request as soon as possible.

4. Obtain a total of four ***(4) references*** attesting to your character and professional abilities. To obtain this verification, mail the enclosed **Reference Form** to each the following:

   - Chief of Staff in the hospital where you currently hold staff privileges;
   - Hospital Administrator in the hospital where you currently hold staff privileges;
   - Two (2) additional practicing physicians.

   If you **do not** currently hold staff privileges, mail the **Reference Form** (page 18) to each the following:

   - Chairman of the department where you had your major training;
   - Director of Residency or Fellowship Training Program;
   - Two (2) additional practicing physicians.

   Letters or other forms submitted in lieu of the Reference Form will not be accepted. ***The Board must receive these forms directly from the reference source.*** Make copies of the form as needed.

5. Submit a notarized copy of your American Board of Medical Specialty Certificate(s), if applicable.

6. In order to dispense, prescribe, store, or order controlled substances, you must obtain a **Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration.** The Rhode Island CSR Application is available on page 19. After you obtain your Rhode Island CSR you can apply for a federal DEA Number. An application for the federal DEA Number can be obtained by contacting DEA: DEA Phone Number (617) 557-2200. Web Site: http://www.deadiversion.usdoj.gov/drugreg/reg_apps/

The application process is not considered complete until your Board application, applicable forms and FCVS Physician Information Profile are received in a manner satisfactory to the Board. Neither the Board nor FCVS will accelerate processing of one applicant at the expense of others for any reason. Once completed, your application will be reviewed and you will be contacted in writing. Be advised that you may be required to appear for an interview. Please allow 7-10 working days following the Board meeting for your wallet size license card to be mailed to you. [NOTE: You may **not** practice medicine in Rhode Island until you have received a license number.]

Special Notice about Malpractice Information

In Section 17, **"Malpractice"**:

Pursuant to R.I.G.L. § 5-37-9.2, the Rhode Island Board of Medical Licensure and Discipline must collect data regarding your malpractice history. You are required to report to the Board all actual settlement or jury verdict amounts in the past 10 years. The Board will **not** make actual settlement or verdict amounts available to the public. It must report the fact that a payment was made and how it compared to other payments made in your specialty. For each incident you report, you must include documentation that verifies the date, place, reason and disposition of the matter.

State of Rhode Island
Board of Medical Licensure and Discipline
Application for License to Practice Allopathic Medicine

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

1. Name(s)

This is the name that will be printed on your license and reported to those who inquire about your license. Do not use nicknames, etc.

ALL questions MUST be answered. Enter "NA" for any question that is NOT APPLICABLE.

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Degree (MD, DO)

Maiden, if applicable

Name(s) under which originally licensed in another state, if different from above (First, Middle, Last).

2. Social Security Number

U.S. Social Security Number

Please refer to "Mandatory Addendum to License Application" on the last page of this application

3. Gender

☐ Male ☐ Female

4. Date and Place of Birth

Month Day Year 1 9

City and State; **OR** Province and Country, etc., if NOT U.S.

5. Home Address

It is your responsibility to notify the board of all address changes,

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City State Zip Code

Country, If NOT U.S. Postal Code, If NOT U.S.

Home Phone Home Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

6. Business Address

It is your responsibility to notify the board of all address changes.

This address will appear on the Department of Health web site.

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

State Zip Code

City Postal Code, If NOT U.S.

Country, If NOT U.S.

Business Phone Extension Business Fax

7. Preferred Mailing Address

Please check ONE

☐ Please use my **Home Address** as my preferred mailing address

☐ Please use my **Business Address** as my preferred mailing address

8. Speciality of Practice

See ABMS Specialty Code list (page 15).

DOCUMENTATION:
You must provide a notarized copy of your ABMS certificate(s).

Primary Specialty Code[1] ☐☐☐☐☐☐☐☐☐☐

Board Certified?: ☐ Yes ☐ No

If Yes, Year Certified/Recertified: ☐☐☐☐ Year

Secondary Specialty Code[1] ☐☐☐☐☐☐☐☐☐☐

Board Certified?: ☐ Yes ☐ No

If Yes, Year Certified/Recertified: ☐☐☐☐ Year

You may report "None," "Other" or "Unknown" if necessary.

9. Practice Information

A. Specify where in this State you intend to practice, and list type of practice.

ACD = Academia
ADM = Administration
FTY = Facility
FEL = Fellowship
GRP = Group
HSP = Hospital
HMO = HMO
OFC = Office
RES = Research
OTH = Other

If necessary, continue on a separate 8½ x 11 sheet of paper.

Location #1 ☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Practice Type (See Codes) ☐☐☐

Location #2 ☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Practice Type (See Codes) ☐☐☐

Location #3 ☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Practice Type (See Codes) ☐☐☐

B. Identify any translation services that may be available at your primary practice location.

_____

_____

10. Practice History

10A. Training History

Account for each year of training activity from medical school through the present. Explain gaps on separate 8 1/2" X 11" sheet of paper.

10B. Work History

Account for each year of work activity from medical school through the present. Explain gaps on separate 8 1/2" X 11" sheet of paper.

Month	Year		Month	Year	Name and Location of Facility: NOTE: You may continue information on a separate sheet of paper.
☐☐	☐☐	—	☐☐	☐☐	_____
☐☐	☐☐	—	☐☐	☐☐	_____
☐☐	☐☐	—	☐☐	☐☐	_____
☐☐	☐☐	—	☐☐	☐☐	_____
☐☐	☐☐	—	☐☐	☐☐	_____
☐☐	☐☐	—	☐☐	☐☐	_____
☐☐	☐☐	—	☐☐	☐☐	_____
☐☐	☐☐	—	☐☐	☐☐	_____

10C. **MedicalSchool Faculty Appointments**

Identify any appointments to medical school faculties and indicate as to whether you have had responsibility for graduate medical education within the most recent (10) years.

_____

_____

_____

_____

_____

_____

11. Medical Licensure

List all states or countries in which you are now, or ever have been licensed to practice medicine or any other profession.

State/Country:			State/Country:		
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive
_____	☐ Active	☐ Inactive	_____	☐ Active	☐ Inactive

DOCUMENTATION: Send a Reciprocity Release Form to each entity. *(See page 17)*

12. Board Discipline

List any final disciplinary actions by licensing boards in other states.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

☐ Check here if not applicable.

Licensing Board (abbreviate) and Nature of Action (e.g. TX - Professional Misconduct):

	Month	Year	Type of Discipline:
_____			_____
_____			_____
_____			_____
_____			_____
_____			_____
_____			_____
_____			_____

13. Hospital Privileges

List the name and address of ***all*** hospitals where you have ever held any type of privileges (e.g., courtesy, admitting, etc.).

NOTE:
This section is continued on the next page.

Month Year — Month Year Type of Privileges

Name of Hospital

City State Zip/Postal Code –

Month Year — Month Year Type of Privileges

Name of Hospital

City State Zip/Postal Code –

Month Year — Month Year Type of Privileges

Name of Hospital

City State Zip/Postal Code –

Month Year — Month Year Type of Privileges

Name of Hospital

City State Zip/Postal Code –

13. Hospital Privileges

Continued from previous page.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Month Year — Month Year Type of Privileges

Name of Hospital

City State Zip/Postal Code

Month Year — Month Year Type of Privileges

Name of Hospital

City State Zip/Postal Code

Month Year — Month Year Type of Privileges

Name of Hospital

City State Zip/Postal Code

Month Year — Month Year Type of Privileges

Name of Hospital

City State Zip/Postal Code

14. Hospital Discipline

List any revocation of hospital privileges for reasons related to competence or quality of patient care that have been taken by the hospital's governing body or any other official of the hospital after procedural due process has been afforded.

Also report resignation from or the non-renewal of medical staff privileges or the restriction of privileges at a hospital during the course of an investigation.

☐ Check here if not applicable.

Month Day Year Type of Action

Name of Hospital

Month Day Year Type of Action

Name of Hospital

Month Day Year Type of Action

Name of Hospital

Month Day Year Type of Action

Name of Hospital

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

15. Malpractice

Report all medical malpractice court judgments, medical malpractice arbitration awards and settlements in which payment was awarded or made to a complaining party since September 1, 1988 in any state in which you have held an active license since September 1, 1988. Be certain to read and initial the statement at the bottom of the section.

If necessary, you may continue on a separate 8½ x 11

Month	Day	Year	Amount Paid	Basis for Complaint

_____ I certify that I have read and understand the information provided on page 5 "Special Notice about Malpractice Information."
Initials

16. Criminal Convictions

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are there any formal charges pending? ☐ Yes ☐ No

Abbreviation of State and Conviction[1] (e.g. CA - Illegal Possession of a Controlled Substance):

	Month	Year

[1]For purposes of this section, a person shall be deemed to be convicted of a crime if he/she plead guilty or if he/she was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of Nolo Contendere in any state.

17. Questions

Check either Yes or No for each question.

If you answer "Yes" to any question, you are required to furnish complete details, including date, place, reason and disposition of the matter.

1.	During any Professional/Medical Education, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?	☐ Yes ☐ No
2.	During any Professional/Medical Education, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?	☐ Yes ☐ No
3.	During any postgraduate training, were you ever dismissed, suspended, restricted, put on probation, or otherwise acted against or did you take a leave of absence for medical reasons?	☐ Yes ☐ No
4.	During any postgraduate training, were you ever requested to leave or did you leave, temporarily or permanently, prior to completion of training?	☐ Yes ☐ No
5.	Are there any charges or investigations pending, in any state, against you?	☐ Yes ☐ No
6.	Have your staff privileges at any hospital, nursing home, or other health care facility or health care provider or HMO ever been reduced, revoked, or suspended or have you voluntarily surrendered your clinical privileges from any such unit or facility while under investigation in any state?	☐ Yes ☐ No
7.	Have you ever had any disciplinary action(s) taken, or is any pending, against your: License to practice medicine, DEA Permit, State Controlled Substances Registration, Medicare Privileges, Medicaid Privileges, or are any complaints pending in any state?	☐ Yes ☐ No
8.	Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation?	☐ Yes ☐ No
9.	Have you ever failed to pass an examination for medical licensure (including National Boards, FLEX, USMLE)?	☐ Yes ☐ No

Note: If you answered "**yes**" to any of these questions, you must attach a typed explanation on a separate sheet of paper.

18. Physician Honors and Peer Reviewed Publications (Optional)

List any information regarding professional or community service awards and/or information regarding publications in peer-reviewed medical literature within the most recent 10 years.

Do **NOT** submit your curriculum vitae to satisfy the requirements of this section.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Awards, Honors:

Publications:

19. Professional and Community Memberships (Optional)

List any professional and community memberships.

Do **NOT** submit your curriculum vitae to satisfy the requirements of this section.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Professional and Community Memberships:

20. Affidavit of Applicant

Complete this section and sign in the presence of a notary public. Make sure that you and the notary public have completed all components accurately and completely.

I, _____, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentality's (local, state, federal or foreign) to release to the Rhode Island Board of Medical Licensure and Discipline any information which is material to my application for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice medicine/ surgery in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under the Federal and State Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Medical Licensure and Discipline of any change in the answers to these questions after this application and this affidavit is signed.

_____ Signature of Applicant

_____ Date of Signature (MM/DD/YY)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____, by _____, who is personally known to me or has produced _____ as documentation and did/did not take an oath.

_____ Name of Notary (Print, Type or Stamp)

_____ Signature of Notary

Notary Seal

_____ Notary No/Commission No.

_____ Commission Expiration Date (MM/DD/YY)

21. Recent Photograph

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport photo, clear, front view, full face without a hat or dark glasses.

Full length photos, black and white or computer-generated photos will not be accepted.

Affix Photo Here

Sign your name on the line provided, partly upon the page and partly upon the photograph, and provide the date it was taken.

State of Rhode Island and Providence Plantations
Department of Health

Office of the Director

Message from the Director of Health

Dear Applicant:

The following page contains questions regarding your race and ethnicity. The Department of Health is attempting to promote diversity among health professionals. The Department can measure its success in promoting diversity by identifying gaps in our diversity. Also, it will utilize this information in order to select members for professional regulatory boards at the Department of Health.

Answering these questions is entirely voluntary. Your willingness to provide this information will not affect your licensure in any way. Data will be used only in accordance with Title VI of the Civil Rights Act of 1964.

Rhode Island has a strong interest in promoting diversity among the health professions. Offering culturally competent health care, better serving minority communities, providing role models for minority youth and encouraging minority persons to become health professionals will make our communities healthier and safer.

Please join us in our attempts to attain these worthy goals by answering the questions on the following page.

Sincerely,

Patricia A. Nolan, MD, MPH
Director of Health

*VOLUNTARY RACE/ETHNICITY QUESTIONS**

This information is completely voluntary and will NOT affect your Application in any way.

Note: *This information is voluntary and refusal to provide it will not impact on the renewal of your license. It will be confidential and used only in accordance with Title VI of the Civil Rights Act of 1964.*

1. **Ethnicity:** Are you of Hispanic or Latino ethnicity? ☐ Yes ☐ No

2. **Race:** Please indicate your race below. (Check as many boxes that apply)

☐ American Indian or Alaska Native ☐ Black or African American ☐ White

☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Other (Specify Below)

Please specify Race, if you answered "other" above

For the purposes of the above questions kindly use the "Federal Minimum Data Collection" explanations listed below:

Hispanic or Latino

A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin" can be used in addition to "Hispanic or Latino."

American Indian or Alaskan Native.

A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian (new group does not include Pacific Islanders).

A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan , Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American.

A person having origins in any of the Black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American".

Native Hawaiian or Other Pacific Islander.

A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.

White

A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

***This information is being collected in accordance with the Department of Health's Policy for Maintaining, Collecting and Presenting Data on Race and Ethnicity. The mission of the Department is to protect and promote the health of the population and to prevent disease through life-style change, environmental change, and health services delivery. A copy of this policy is available upon request.**

AMERICAN BOARD OF MEDICAL SPECIALITY (ABMS) CODE TABLE

Code	Speciality	Code	Sub-Specialty
A&I	Allergy and Immunology	CL1	Clinical and Laboratory Immunology
		DL1	Diagnostic Laboratory Immunology
Anes	Anesthesiology	CCM	Critical Care Medicine
		PM	Pain Management
CRS	Colon and Rectal Surgery		
D	Dermatology	CLDI	Clinical and Laboratory Dermatological Immunology
		DI	Dermatological Immunology
		DP	Dermatopathology
EM	Emergency Medicine	MT	Medical Toxicology
		PEM	Pediatric Emergency Medicine
		SM	Sports Medicine
FP	Family Practice	Ger	Geriatric Medicine
		SM	Sports Medicine
IM	Internal Medicine	AI	Allergy and Immunology
		AM	Adolescent Medicine
		CE	Cardiac Electrophysiology
		CCEP	Clinical Cardiac Electrophysiology
		CCM	Critical Care Medicine
		CLI	Clinical and Laboratory Immunology
		CV	Cardiovascular Disease
		DLI	Diagnostic Laboratory Immunology
		EDM	Endocrinology, Diabetes and Metabolism
		En	Endocrinology
		Ge	Gastroenterology
		Ger	Geriatric Medicine
		Hem	Hematology
		Inf	Infectious Disease
		Nep	Nephrology
		Onc	Medical Oncology
		Pul	Pulmonary Disease
		Rhu	Rheumatology
		SM	Sports Medicine
MGCBCGn	Clinical Biochemical Genetics		
MGCBMG	Clinical Biochemical Molecular Genetics		
MGCCytG	Clinical Cytogenetics		
MGCCGen	Clinical Genetics (M.D.)		
MGCMGn	Clinical Molecular Genetics		
MGPhdMG	Medical Genetics		
NS	Neurological Surgery (NS-F indicates foreign certificate)		
NuM	Nuclear Medicine		
ObG	Obstetrics and Gynecology	CCM	Critical Care Medicine
		GO	Gynecologic Oncology
		MF	Maternal and Fetal Medicine
		RE	Reproductive Endocrinology
Oph	Ophthalmology		
OrS	Orthopedic Surgery	HS	Hand Surgery
OMT	Osteopathic Manipulative Therapy		
Oto	Otolaryngology		
Path AP/CP	Anatomic and Clinical Pathology	BB	Blood Banking
Path AP	Anatomic Pathology	BBTM	Blood Banking Transfusion Medicine
Path CP	Clinical Pathology	ChemP	Chemical Pathology
		CytoP	Cytopathology
		DP	Dermatopathology
		FP	Forensic Pathology
		Hem	Hematology
		IP	Immunopathology
		MMB	Medical Microbiology
		NP	Neuropathology
		PdP	Pediatric Pathology
		RIP	Radioisotopic Pathology
Ped	Pediatrics	AI	Allergy and Immunology
		AM	Adolescent Medicine
		CCM	Pediatric Critical Care Medicine
		Cd	Pediatric Cardiology
		CLI	Clinical and Laboratory Immunology
		DLI	Diagnostic Laboratory Immunology
		En	Pediatric Endocrinology
		Ge	Pediatric Gastroenterology
		HO	Pediatric Hematology-Oncology
		Inf	Pediatric Infectious Disease
		MT	Medical Toxicology
		Ne	Pediatric Nephrology
		NP	Neonatal-Perinatal Medicine
		PEM	Pediatric Emergency Medicine
		Pul	Pediatric Pulmonology
		Rhu	Pediatric Rheumatology
		SM	Sports Medicine
PMR	Physical Medicine and Rehabilitation		
PS	Plastic Surgery	HS	Hand Surgery
PrM AM	Aerospace Medicine	MT	Medical Toxicology
PrM GPM	General Preventive Medicine	UM	Undersea Medicine
PrM OM	Occupational Medicine		
PrM PH	Public Health		
PrMPHGPM	Public Health and General Preventive Medicine		
ChiN	Neurology with Special Qualifications in Child Neurology	AdP	Addiction Psychiatry
		ChAP	Child and Adolescent Psychiatry
N	Neurology	ChiN	Child Neurology
Psyc	Psychiatry	C/Nph	Clinical Neurophysiology
		FPsy	Forensic Psychiatry
		Ger	Geriatric Psychiatry
Rad DR	Diagnostic Radiology	NR	Nuclear Radiology
Rad DRnt	Diagnostic Roentgenology	PR	Pediatric Radiology
Rad NM	Nuclear Medicine	VIR	Vascular and Interventional Radiology
Rad R	Radiology		
Rad Rnt	Roentgenology		
Rad RO	Radiation Oncology		
Rad RT	Radium Therapy		
Rad TR	Therapeutic Radiology		
Rad DRMNP	Diagnostic Radiology and Medical Nuclear Physics		
Rad DRP	Diagnostic Radiological Physics		
Rad MNP	Medical Nuclear Physics		
Rad RP	Radiological Physics		
Rad RRP	Roentgen Ray Physics		
Rad TDRP	Therapeutic and Diagnostic Radiological Physics		
Rad TRNP	Therapeutic Radiology and Nuclear Medicine Physics		
Rad TRP	Therapeutic Radiological Physics		
Rad XRP	X-Ray and Radium Physics		
S	Surgery	GVS	General Vascular Surgery
		HS	Hand Surgery
		PdS	Pediatric Surgery
		SCC	Surgical Critical Care
TS	Thoracic Surgery		
U	Urology		

This list was taken from the ABMS Directory of Board Certified Medical Specialists.

APPLICATION CHECKLIST

Please review the following checklist to ensure you have satisfied all components of the application process. Some items may not apply.

Board Application

- ☐ I have read and understand the "Instructions for Completing the Board Application."
- ☐ I have completed the Rhode Island Board application as instructed (pages 6-12).
- ☐ I have completed Section 20, **"Affidavit of Applicant"** and had the form notarized by a notary public.
- ☐ I have attached a photograph to Section 21, **"Recent Photograph"** as instructed. I have verified that it meets the photograph requirements as stated in the application.
- ☐ I have a **check** or **money order** made payable (in U.S. funds only) to the General Treasurer, State of Rhode Island in the amount of $437.50 (or $537.50 with CSR application) and attached the payment as instructed.
- ☐ I have arranged my Board Application materials in following order:
    1. Fee (attached as instructed).
    2. Board Application (cover page, and pages 6-12)
    3. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application MUST indicate the section for which the information is being reported.
    4. RI Uniform Controlled Substances Registration (CSR) (page 19) (If Applicable).
- ☐ I have mailed the above application materials directly to the Licensing Office, Department of Health.

Required Forms / Letters

- ☐ I have completed and mailed the following forms as instructed:
    1. Reciprocity Release Form(s) (Licensure Verification)
    2. Practitioner Request for Information Disclosure (National Practitioner Data Bank)
    3. **Four (4)** Reference Forms

FCVS Application

- ☐ I have completed the FCVS application, and submitted all required forms, documents, and fee directly to FCVS.

Note: In order to dispense, prescribe, store, or order controlled substances, you must obtain a **Rhode Island Controlled Substance Registration (CSR) and a Drug Enforcement Administration (DEA) Registration.**

The Rhode Island CSR Application is available on page 19. After you obtain your Rhode Island CSR you can apply for a federal DEA Number. An application for the federal DEA Number can be obtained by contacting DEA: DEA Phone Number (617) 557-2200. Web Site: http://www.deadiversion.usdoj.gov/drugreg/reg_apps/

Substitute forms are not acceptable - This form may be duplicated as needed .

Rhode Island Board of Medical Licensure and Discipline

Room 205, Three Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

RECIPROCITY RELEASE FORM

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires that the following form be completed by the jurisdiction in which I am now or was previously licensed. This constitutes your authority to release all information in your files, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

Print/Type Full Name _____ Signature _____ Date _____

Previous Names Used _____ Social Security Number _____ Date of Birth _____

License Number _____ Date Issued _____

THIS SECTION TO BE COMPLETED BY THE MEDICAL BOARD

Basis for Issuing License:

☐ NBME ☐ NBOME ☐ USMLE ☐ LMCC ☐ FLEX _____ (State Sponsor) ☐ State Exam _____ (State)

If a combination of exams were taken, please list the specific combination: _____

License Status: ☐ Active ☐ Inactive ☐ Lapsed	**Original Date Issued:**	**Expiration Date:**

Questions:

1. Has this physician ever been investigated by your Board? ☐ Yes ☐ No
2. Has this physician incurred any disciplinary proceedings in your state, or is any action pending? ☐ Yes ☐ No
3. Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended, revoked or placed on probation? ☐ Yes ☐ No
4. Are you aware of any information about this physician submitted to the National Practitioner Data Bank? ☐ Yes ☐ No
5. Do you know of any information that may discredit this person? ☐ Yes ☐ No

If you answer "Yes" to questions 1-5, please provide a written explanation below, and attach a copy of all supporting documentation (e.g., Board order, complaint, etc.).

_____

_____

_____

Certification:

Signature _____ Date _____

Type or Print Name _____

Title _____

Full Name of Licensing Board _____

Please Affix Board Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

Substitute forms are not acceptable - This form may be duplicated as needed .

Rhode Island Board of Medical Licensure and Discipline

Room 205, Three Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

REFERENCE FORM

I am applying for a license to practice medicine in the State of Rhode Island. The Rhode Island Board of Medical Licensure and Discipline requires this reference form to be completed as part of my application process. This constitutes your authority to provide information about my character and professional abilities, favorable or otherwise, directly to the Rhode Island Board of Medical Licensure and Discipline at the above address.

Applicant Should Complete this Section Only:

Print/Type Full Name _____ Signature _____ Date _____

Social Security Number _____ Date of Birth _____

EVALUATION

Based upon demonstrated performance and composite of evaluations by supervisors on file.

		Superior	Good	Fair	Poor	No Info.
Basic Clinical Knowledge						
Professional Judgement						
Clinical Competence and Skill						
Reliability/Sense of Responsibility						
Patient Management						
Ethical Conduct						
Physician-Patient Relationship						
Ability to Work with Other Hospital Staff						
Appearance						
Medical Recordkeeping						
Ability to Communicate Verbally						
	Overall Rating:					

Recommendation:

☐ Recommended Highly without Reservation ☐ Recommended as Qualified and Competent ☐ Recommended with Reservation

☐ No Comment ☐ Not Recommended

Additional Comment (use reverse side if necessary)**:**

_____

_____

You must affix your institution's official seal or have your signature notarized.

Printed Name of Reference _____ Signature _____

Title _____ Date _____

Relationship to Applicant _____

Please Affix Hospital or Notarial Seal Here

Please return directly to the Board at the above address. Thank you for your prompt cooperation.

*IF Applying for CSR, this Application **MUST** BE SUBMITTED ALONG WITH YOUR LICENSE APPLICATION.*
Substitute forms are not acceptable

Rhode Island Board of Medical Licensure & Discipline

Room 205, 3 Capitol Hill
Providence, RI 02908-5097
(401) 222-3855

Rhode Island Uniform Controlled Substances Act Registration (CSR)

I am applying for a Rhode Island Uniform Controlled Substances Act Registration (CSR). **I understand that this application MUST be submitted along with my Board Application . I also understand that there is an additional $100.00 fee for this Registration and that the check or money order for $537.50 (NON-REFUNDABLE Board Application fee ($437.50) PLUS CSR Application fee ($100.00)) must be made out to the "RI General Treasurer".**

Print/Type Full Name _____ Business Name _____

Signature _____ Business Address _____ Business Telephone _____

Date _____ Business Fax _____

Complete this application for registration to prescribe controlled substances in the State of Rhode Island

The Rhode Island Uniform Controlled Substances Act can be accessed at the following web Site:
http://www.rilin.state.ri.us/Statutes/Title21/21-28/index.htm

Drug Schedule (Check all that apply)

☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ ScheduleV

A CSR is not required if there will be no controlled substances prescriptions prescribed in this state.

The CSR is renewed at the same time that the professional license is renewed.

NOTE: Read Important Information on the bottom of this application.

A Copy of the DEA Registration must be provided to the Medical Board within 60 Days of its issuance by the DEA. The DEA Registration must be issued to your Rhode Island Practice Address in order for it to be valid. If you are relocating from another state, you need to apply for a DEA Registration that is specific to Rhode Island. See The bottom of this form for information on how to contact DEA.*

All Applicants MUST answer the following:

A. Has the applicant been convicted of, or entered a plea of nolo contendere to a violation of any state or federal law relating to manufacturing, distributing, possessing, prescribing, administering or dispensing of drugs presently defined as controlled substances under Chapter 21-28, General Laws of Rhode Island? ☐ Yes ☐ No

B. Has the registration application or registration of the applicant, corporation, firm, partner, or officer of the applicant been surrendered, revoked, suspended or denied under any law of the United States or of any state relating to drugs presently defined as controlled substances under Chapter 21-28 of the General Laws of Rhode Island, or is such action pending? ☐ Yes ☐ No

If you answered "Yes" to question "A" or "B" attach an explanation to this form.

Important Information

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration by the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "**VOID**". Licensed drug facilities and licensed practitioners with prescriptive privileges, cannot dispense, possess, store or ship controlled substances in or into the State of Rhode Island without a valid drug facility or professional license. Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. Practitioners may only prescribe, dispense, possess, and store controlled substances within their particular "scope of practice". "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR, and federal DEA Registration, licensed drug facilities, and practitioners with prescriptive privileges, may dispense or possess non-controlled prescription medications under its facility or professional license. A CSR will not be granted to an applicant whose BOARD licensure application is "pending" in this state.

A Rhode Island Controlled Substances Registration must be obtained prior to applying for the DEA Registration. Federal regulations require that applicants comply with individual state requirements prior to issuance of a DEA Registration. Once the CSR is issued, applicants must apply to the U.S. Drug Enforcement Administration for a federal registration using that agency's DEA Form 224 (New Application for Retail Pharmacy, Hospital/Clinic, Practitioner, Teaching Institution, or Mid-Level Practitioner). Applicants may apply on-line for the DEA Registration at the following web site: http://www.deadiversion.usdoj.gov/drugreg/reg_apps/

*You can also receive an application, or check the status of a pending DEA Registration by contacting the Drug Enforcement Administration at the following location: Registration Unit, US Drug Enforcement Administration, JFK Federal Building, 15 New Sudbury Street, Boston, MA 02203-0131, Telephone (888) 272-5174.

NOTE:

- Schedules II, III, and IV of section 21-28-2.08 will become void unless dispensed within thirty (30) days of the original date of the prescription.
- Prescriptions in schedules III, IV and V cannot be written for more that one hundred (100) dosage units and not more than one hundred (100) dosage units maybe dispensed at one time. For purposes of this section, a dosage unit shall be defined as a single capsule, tablet or suppository, or not more than one (1) teaspoon of an oral liquid.
- Prescriptions in schedule II may be written for up to a 30-day supply, with a maximum of two hundred and fifty (250) dosage units, as determined by the prescriber's directions for use of the medication.

NOTE: IF APPLYING FOR CSR, THIS APPLICATION MUST BE SUBMITTED ALONG WITH YOUR LICENSE APPLICATION

Applicant: Print your complete last name >

State of Rhode Island and Providence Plantations

DEPARTMENT OF HEALTH
Office of the Director
Cannon Building
3 Capitol Hill
Providence, RI 02908-5097

Mandatory Addendum to License Application

Verification of Social Security Number/Federal Employer Identification Number and affidavit concerning taxpayer status

Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

Signature	Date	Social Security Number (SSN) or Federal Employer Identification Number (FEIN)

Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.

This form MUST be completed, signed and attached to your license application in order for us to process your application.